

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005087	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/06/2016
NAME OF PROVIDER OR SUPPLIER ST VINCENT SALEM HOSPITAL INC		STREET ADDRESS, CITY, STATE, ZIP CODE 911 N SHELBY ST SALEM, IN 47167		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 33212 Facility Number: 005087</p> <p>Type of Survey: State Licensure Off Site JCAHO Accreditation Survey</p> <p>Date of JCAHO On Site Survey - Hospital full survey 01/5-6/2016</p> <p>Date of ISDH off site review - 4/14/2016</p> <p>Based on review of the 01/6/2016 JCAHO Accreditation Survey Report, it has been determined that St. Vincent Salem Hospital meets the requirements for Hospital Licensure in Indiana for 2016.</p>	S 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE